



Patient Intake – Update

Today's Date ___/___/___

Name _____ Date of Birth ___/___/___ SS# ___-___-___

Address _____ City _____ State _____ Zip _____

Please check box for preferred communication means E-Mail _____

Home Phone(____)____-____ Work Phone(____)____-____ Cell Phone(____)____-____

Preferred language: English Spanish _____ Height ___'___" Weight _____ lbs

Ethnicity: Hispanic or Latino NOT Hispanic or Latino **Race:** American Indian or Alaska Native

African American or Black Asian Hispanic or Latino Hawaiian or Pacific Islander White

If patient is a minor: Parent/Guardian _____ Relationship _____

Emergency contact _____ Phone _____ Physician: _____

Current Complaints	Date of Onset	Probable cause

History of Current Complaints None If this is a recurrent problem please describe the **initial cause**, the frequency, how you have treated in the past, and if past treatment was successful:

NONE **For the PRESENTING CONDITION and OTHER CURRENT CONDITIONS which you are treating, please list ALL providers, treatments and outcomes**

Recommended by Self / Doctor / therapist	Treatment / Testing PT, exercises, medications, ice, heat, x-ray, MRI, CT, labs	Outcome partial or temp relief, no help, etc.

NONE **Please list any other serious illnesses or conditions which you have been diagnosed and/or treated (cancer, heart, diabetes, mental, TB, high blood pressure, high cholesterol, HIV, asthma etc.)**

Condition	Date diagnosed	Treatment – if hospitalized please write H	Outcome

NONE **Prescription or over the counter medications AND supplements you are currently taking**

Name	Reason	Dosage	Frequency	How long	Side effects

NONE **Please list all significant trauma (auto, lifting, fracture, dislocation, sport)**

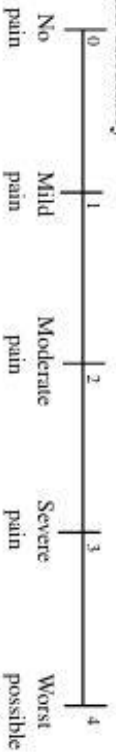
Type of trauma	Date	Body parts injured	Treatment please if hospitalized write H	Residual problems

Functional Rating Index

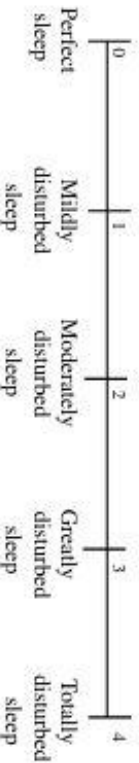
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

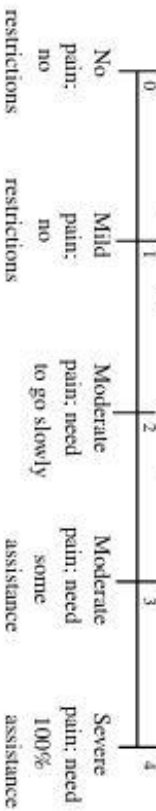
1. Pain Intensity



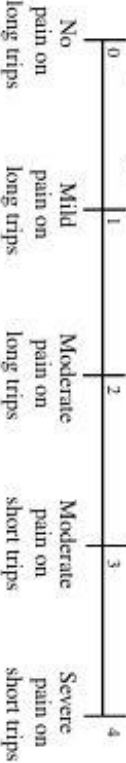
2. Sleeping



3. Personal Care (washing, dressing, etc.)



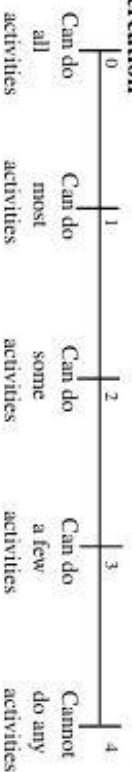
4. Travel (driving, etc.)



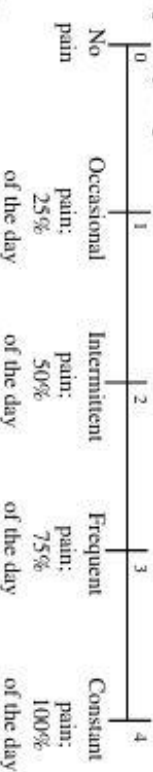
5. Work



6. Recreation



7. Frequency of pain



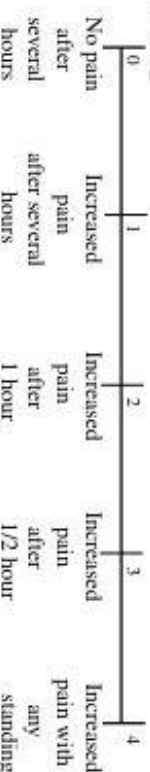
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Date _____

Total Score _____

PAIN CHART

Name _____ DOB _____ - _____ - _____ Date _____ - _____ - _____

Please mark on the body diagrams all areas of pain, discomfort, or altered sensation, and use the key below to identify quality of each.

A = ache

B = burning

E = electrical

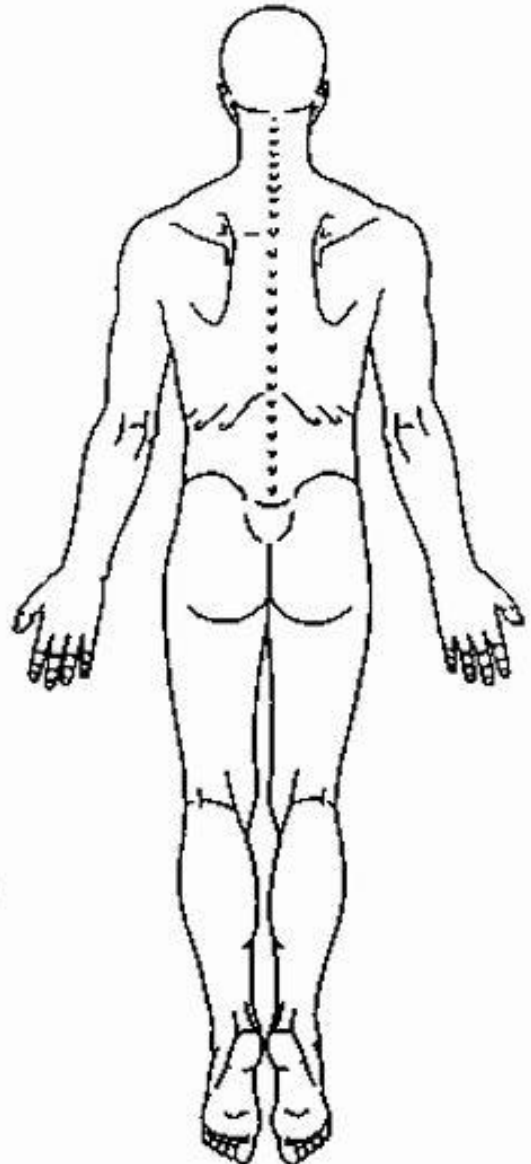
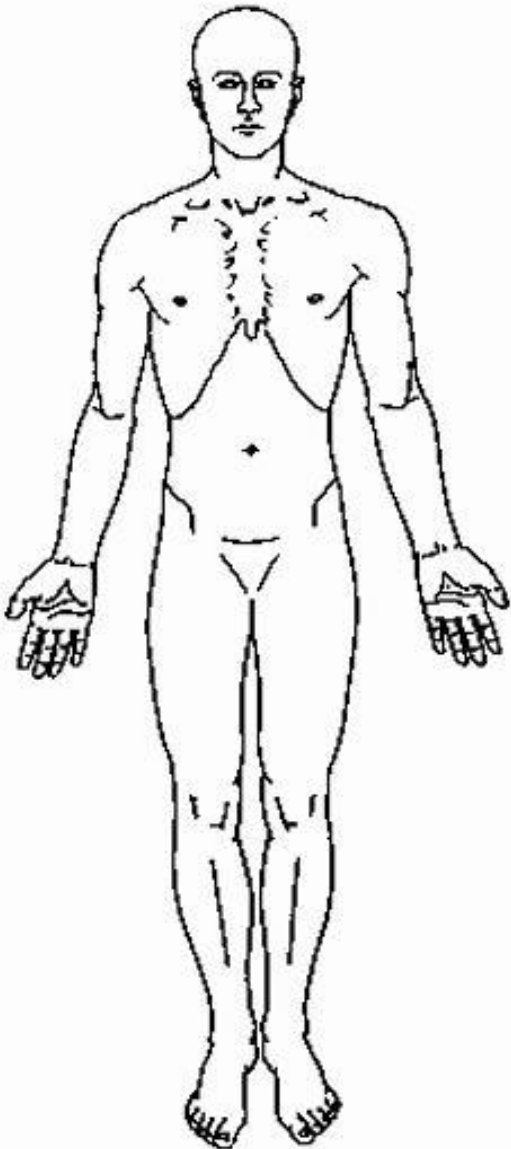
S = stabbing

P = pins & needles

N = numb

O = other

Th = throbbing



Elmhurst Chiropractic Clinic

FINANCIAL CONSULTATION

Primary Insurance _____ ID# _____ Group # _____ Subscriber _____

Subscriber ID _____ Subscriber DOB _____ Patient Relationship to Subscriber _____

Secondary Insurance _____ ID# _____ Group # _____ Subscriber _____

Subscriber ID _____ Subscriber DOB _____ Patient Relationship to Subscriber _____

- _____(Pt. Initials) **OUR FEES:** All fees for services are based on the degree of complexity, the number of areas involved, and the time spent evaluating, treating, and instructing (do's & don'ts, exercises, etc.)
Evaluation fees for new patients range from \$80.00 - \$287.00.
Standard treatment fees range from \$45 - \$82.
- _____(Pt. initials) **MISSED APPOINTMENT FEE:** The fee for a missed appointment is a minimum of \$40 for a basic chiropractic follow-up visit. It will be more for longer appointment times. Please provide 24 hours notice if you need to cancel or reschedule an appointment.
- _____(Pt. initials) **DISCOUNT PLANS:** In order to participate in any discount plan offered, payment must be made at time of service.
- _____(Pt. Initials) **BILLING STATEMENTS:** Statements are generated the first Tuesday of the month and mailed out within 1-2 days. Balances over 90 days are past due and a 9% (annual) interest charge will be assessed. If required for recovery of past due accounts, you will be charged the collection and/or legal fees. A \$20 fee will be charged for returned checks.
- _____(Pt initials) **GENERAL INSURANCE PAYMENT POLICY:** Your portion of the services (full amount, co-pay, deductible, etc.) Is due on the day of service. Per your insurance plan, evaluation on this day may not be covered by insurance and will be your responsibility.
 - _____(Pt initials) If your insurance covers chiropractic treatment, we will provide for your insurance company all necessary documentation, but we cannot accept responsibility for non-payment, late payment, or for negotiating a disputed claim. Your insurance policy is a contract between you and your carrier. **Even though we may have been given information by your insurance company regarding the benefits of your plan, this is not a guarantee of payment.**
 - _____(Pt initials) **After 90 days, unpaid insurance claims will be converted to cash claims.**
 - _____(Pt initials) We cannot reach the insurance company at this time (after hours, weekend, other). Until we can determine and discuss limitations on your plan, you will be responsible for payment on any excluded services.
- _____ (Patient initials) **3RD PARTY OR WORK INJURY:** Bills will be submitted to the **PI or L&I** insurance carrier. I understand that if the claim is denied by the insurance, I will be responsible for payment.
- _____ **Payment is expected at Time of Service unless prior arrangements are made. If you are unable to pay your portion at time of service, please alert the front desk.**

By signing this document, you are authorizing us to bill and receive insurance payments related to your treatment.

Patient signature _____ Date _____

Elmenhurst Chiropractic Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____

Date of Birth: _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices, effective February 16th, 2026, which describes how my health information may be used and disclosed, my rights, and the practice's legal duties.

I understand that the Notice describes the uses and disclosures of my protected health information by **Elmenhurst Chiropractic** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement
- Communications barriers prohibited obtaining the acknowledgement
- Other (please specify): _____

Employee Name

Today's Date

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss my diagnosis, the nature and purpose of my treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- | | |
|--|---|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> increased symptoms and pain |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> No improvement of symptoms or pain |
| <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> Worsening/aggravation of spinal conditions |
| <input type="checkbox"/> Burns or frostbite (physical therapy) | <input type="checkbox"/> Other _____ |

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment for my current condition and for future conditions for which I may seek treatment.

To be completed by the patient:

print name

signature of patient

date signed

To be completed by the patient's representative:

print name of patient

print name of patient's representative

signature of patient's representative

as: _____
relationship/authority of patient's representative

date signed

To be completed by doctor or staff:

witness to patient's signature

date

Translated by

date